December 2024

Response to Evaluation Questions on Murray-Darling Medical School Network

Thank you for the opportunity to respond to the Evaluation of the Murray-Darling Medical School Network (MDMSN).

The College views the development of a strong pathway from school to medical school to Fellowship training and ultimately to rural careers as a central tenet of building a resilient rural medical workforce. As such we are pleased to support the MDMSN initiative and welcome the opportunity to input into its ongoing development, refinement and strengthening.

Response to Evaluation Questions

Question	ACRRM Response
1. What are the potential risks and benefits of end-to-end medical programs for students? How can these risks be mitigated?	***Benefits and Optimisation*** There are significant benefits of end-to-end training and the rural workforce outcomes of models such as James Cook University which has been in place for over two decades now are testament to this. JCU graduates are more than twice as likely as other Australian medical graduates to be working in a regional, rural or remote location. They are also more likely to practice in their region than other Queensland graduates.[1] There are self-evident benefits in enabling people to spend key formative years in the locations or region where you would wish for them to permanently locate. Apart from the obvious opportunity for students to put down roots in the area, this also contributes to

[1] Woolley T, Sen Gupta T, Paton K. (2021) Mid-career graduate practice outcomes of the James Cook University medical school: key insights from the first 20 years. *Rural and Remote Health* 21: 6642. https://doi.org/10.22605/RRH6642

	building the regionalised network of doctors, and training and research facilities that would support and engage these future rural doctors throughout their career. It also enables the course content and delivery and general organisational culture to be bespoke to the needs and priorities of the region. A key element to JCU's success for broader adoption, has been its close relationship with our college. This has strengthened its capacity to point its students to a compelling rural career outcome supported by a community of professional mentors. This is evidenced by the unusually high percentage of JCU graduates (44%) that become GPs or RGs. ***Risks and Mitigation Strategies*** Key risks of end-to-end training would be around: • Potential that medical students may forego learning and training opportunities that are not available in their region, or in their placement at point of time. • Potential restrictions on movement for medical students that may have life experiences that require them to leave the region. • Potential that a regional medical school may overtime become too narrowly focused and lack breadth of training expertise. We view all these risks as manageable and believe the Australian experience has been that our regional medical schools have avoided these potential problems. We do not see need or value in all medical schools offering pathways to every conceivable sub-specialisation, there is need however to ensure students at regional medical schools are not unduly restricted. It is also important to avoid any negative perception of this among prospective students. To address this: • Some flexibility and capacity for movement in and out of the region and from specific rural placements is necessary. • Collaboration with metropolitan universities/campuses may provide a mechanism to enable the full breadth of learning opportunities. • Additionally, digital technologies present a growing range of opportunities to enable training and learning capacity within the regional/rural/remote locations.

	• A focus on the RG model is a key tool to overcome any perception that the rurally-based medical training may restrict professional opportunities. The RG model of care has an expansive scope to allow doctors to address the range of healthcare service needs of their diverse communities. RG registrars, undertake GP training, emergency and secondary care training, as well as advanced specialised training in at least one specialty discipline of their choosing (e.g. obstetrics, mental health, paediatrics, palliative care etc). They practice in GP clinics, hospitals, retrieval services, Aboriginal medical services, RACFs and often in several of these settings concurrently.
2. What mechanisms/strategies are needed for the planning and coordination of student placements (particularly when multiple universities) at: • A regional level (hospitals, general practices, ACCHOs, other community-based providers) • Base/regional hospital level Who needs to be involved?	Some key strategies should include: • Ensuring strong capacity management and reporting across university, prevocational and GP training allocations. • The mapping of training pathways to ensure trainees can be moved through the end-to-end training in an efficient manner and to increase likelihood of training satisfaction. • Regional alignment between the medical schools, Prevocational Medical Councils, colleges and the workforce agencies to considered capacity and supervision requirements.
3. Given the emerging benefit of RCS placements transitioning to regional internships, how can medical student training placement and junior doctor positions be better linked (i.e. how do we put the students where the job opportunities are)?	As above this will involve strong coordination and collaboration between the medical schools, the PMCs, colleges (particularly the GP colleges), workforce agencies and other key groups such as the Rural Generalist Coordinating Units. The John Flynn Rural Prevocational Doctor Training Program may provide one key focus point for coordination which would concentrate efforts upon highly motivated, aspiring rural doctors.
4. What strategies are needed to grow supervision capacity in rural, remote and regional general practice? Who needs to be involved?	Key strategies should include: • Addition of supervision skills to late-stage registrar training to increase the pipeline for supervision skills. ACRRM is currently looking to strengthen its training in this regard. ACRRM has also been strengthening its wider program of supervisor training and professional

	development. It offers a bespoke MOPS program for supervisors within its CPD Home. • Active recruitment of new Fellows in collaboration with the relevant colleges.
5. How do we build aspiration and tangible pathways for rural and Indigenous school students and young people?	Key programs should include the following: • Scholarships and financial support for rural school students to assist them as per need, in their school studies, application to medical school, and in their medical studies. There is opportunity to tie this support to an ongoing requirement to act as a role model, mentor, and ambassador for rural medical careers. For example, support could be tied to commitment from recipients, to continue to engage with their former school community as they progress through the medical program. • Supporting a range of initiatives that build a culture within rural schools that views medical careers as an achievable personal goal. These could include programs for mentoring with rural doctors, programs for medical student ambassadors who liaise with rural schools, and programs for medical school staff to engage directly with rural schools. • Engaging rural community groups and local councils in initiatives to support medical students training in rural towns. These would not only ensure a positive and financially viable rural placement for the medical students but could also promote opportunities for their engagement with young people in the community.
6. What outcome measures should be considered in measuring the success of end-to-end medical programs and what data is: (a) currently available? (b) needed to measure this?	Some key outcome measures should be: • Graduate interest, and subsequent training, and practice in regional, rural and remote areas (applying MMM breakdowns) • Graduate interest and subsequent training, specialisation and employment in specialties that can be practiced in rural areas i.e. GP/RG • Graduate interest and subsequent training/employment in Aboriginal and Torres Strait Islander healthcare (particularly for regions such as Murray-Darling where this represents a key area of healthcare need) • Increased enrolments to the program from students from schools within the region (applying MMM breakdowns).

	Data that could be used for these purposes would be practitioner Ahpra records aligned to graduate, MSOD, and Fellowship data.

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ACRRM acknowledges Aboriginal and Torres Strait Islander peoples as the custodians of the lands and waters where our members and staff work and live across Australia. We pay respect to their elders, lores, customs and Dreaming. We recognise these lands and waters have always been a place of teaching, learning, and healing.